BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against:	)	Case No: 17-2001-118763
	)	OAH No: L2003020259
LORNE HOUTEN, M.D.	)	
Physician's and Surgeon's Certificate #A 39450	)	
Respondent.	)	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby accepted and adopted as the Decision and Order by the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 17, 2009

IT IS SO ORDERED March 18, 2009

MEDICAL BOARD OF CALIFORNIA

Shelton Duruisseau

Shelton Duruisseau, Ph.D.
Chair, Panel A

ORIGINAL

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against: **LORNE HOUTEN, M.D.** Respondent.	Case No. 17-2001-118763 OAH No. L2003020259 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Ron Joseph is the former Executive Director of the Medical Board of California. He brought this action solely in his then official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Richard D. Marino, Deputy Attorney General. Barbara Johnson is the current Executive Director of the Medical Board of California.

2. Respondent Lorne Houten, M.D., is represented in this matter by attorney Perry H. Rausher, Esq., whose address is 24025 Park Sorrento, Suite 220, Calabassas, California 91302..

3. On or about December 20, 1982, the Medical Board of California issued Physician & Surgeon's Certificate No. A39450 to Respondent. Unless renewed, Respondent's

license will expire on January 31, 2010.

JURISDICTION

4. Third Amended Accusation No. 17-2001-118763 was filed before the Board's Division of Medical Quality and is currently pending against Respondent. The Third mended Accusation supersedes all previously filed accusations bearing Case Number 17-2001-118763. Third Amended Accusation No. 17-2001-118763 and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense following the filing of the original accusation. A copy of Third Amended Accusation No. 17-2001-118763 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Third Amended Accusation No. 17-2001-118763. Respondent has also carefully read, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Third Amended Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits that if this matter proceeded to hearing Complainant would be able to present a *prima facie* case on each and every charge and allegation in Third Amended Accusation No. 17-2001-118763.

9. Respondent agrees that his Physician & Surgeon's Certificate No. A39450 is subject to discipline and he agrees to be bound by the imposition of discipline of the Board's

Division of Medical Quality as set forth in the Disciplinary Order below.

CONTINGENCY

10. This stipulation shall be subject to approval by the Division of Medical Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

11. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. In consideration of the foregoing admissions and stipulations, the parties agree that the Division may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician & Surgeon's Certificate No. A39450, issued to Respondent Lorne Houten, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years on the following terms and conditions.

1. **Education Course** Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified,

limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition.

2. **Medical Record Keeping Course** Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **Clinical Training Program** Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine (Program).

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and

which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. The Program's determination whether or not Respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after Respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

4. **Monitoring - Practice/Billing** Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as practice and billing monitors, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including, but not limited to, any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor(s) with copies of the Decision and Third Amended Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Third Amended Accusation, and proposed monitoring plan, the

monitor shall submit a signed statement that the monitor has read the Decision and Third Amended Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice and billing shall be monitored by the approved monitor(s). Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours, and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of Respondent to ensure that the monitor(s) submit(s) the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Board or designee.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of

professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

5. **Prohibited Practice** During probation, Respondent is prohibited from performing surgery until he successfully passes the Clinical Training Program described in Paragraph 3, above. After the effective date of this Decision, the first time that a patient seeking the prohibited services makes an appointment, Respondent shall orally notify the patient that respondent does not perform surgery. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation. Failure to maintain a log as defined in the section, or to make the log available for immediate inspection and copying on the premises during business hours is a violation of probation.

In addition to the required oral notification, after the effective date of this Decision, the first time that a patient who seeks the prohibited services presents to Respondent, Respondent shall provide a written notification to the patient stating that respondent does not perform surgery. Respondent shall maintain a copy of the written notification in the patient's file, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation. Failure to maintain the written notification as defined in the section, or to make the notification available for immediate inspection and copying on the premises during business hours is a violation of probation.

6. **Notification** Prior to engaging in the practice of medicine, the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. **Supervision of Physician Assistants** During probation, respondent is prohibited from supervising physician assistants.

8. **Obey All Laws** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

9. **Quarterly Declarations** Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. **Probation Unit Compliance** Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last,

more than 30 calendar days.

11. **Interview with the Board, or its Designee** Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Board or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

12. **Residing or Practicing Out-of-State** In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically canceled if respondent's periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be canceled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

13. **Failure to Practice Medicine - California Resident** In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Board or its designee in writing within 30

calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically canceled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

14. **Completion of Probation** Respondent shall comply with all financial obligations (e.g., probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

15. **Violation of Probation** Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. **License Surrender** Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Board reserves the right to evaluate respondent's request and to

exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. **Probation Monitoring Costs** Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Perry H. Rausher, Esq. I understand the stipulation and the effect it will have on my Physician and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 2/1/09

2/1/09

LORNE HOUTEN, M.D. (Respondent)
Respondent.

I have read and fully discussed with Respondent Lorne Houten, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 2/1/09

PERRY H. RAUSHER, ESQ.
Attorney for Respondent.

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Board of Medical Quality, Medical Board of California of the Department of Consumer Affairs.

DATED: Feb. 17, 2009

EDMUND G. BROWN JR., Attorney General
of the State of California

PAUL C. AMENT
Supervising Deputy Attorney General

RICHARD D. MARINO
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: LA2002AD1808
HoutenStipNo8.wpd

Exhibit A

Third Amended Accusation No. 17-2001-118763

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against: LORNE HOUTEN, M.D. 22643 Collins Street Woodland Hills, CA 91367 Physician's and Surgeon's Certificate No. A39450 Respondent.	Case No. 17-2001-118763 OAH No. L2003020259 **THIRD AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Barbara Johnston (Complainant) brings this Third Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about December 20, 1982, the Medical Board of California issued Physician's & Surgeon's Certificate Number A39450 to Lorne Houten, M.D. (Respondent). The Physician's & Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2010, unless renewed.

JURISDICTION

3. This Third Amended Accusation[1] is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

A. Section 2004 provides:

"The board shall have the responsibility for the following:

"a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"b) The administration and hearing of disciplinary actions.

"c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

B. Section 2227 of the Code provides:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the division.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

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1. The original, First Amended and Second Amended Accusations were filed on October 15, 2002 ; April 29, 2003; and, October 22, 2003, respectively. This Third Amended Accusation supersedes all previous accusations.

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board."

C. Section 2234 provides:

"The [Medical Board of California] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

". . . ."

E. Section 2266 provides:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

4. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that Respondent committed gross negligence during his care, treatment and management of Patients N.J. and R.D.,[2] as follows:

Patient N.J.

A. On or about February 12, 2000, Patient N.J., a 48 year-old male, presented to respondent for surgery. The surgery was conducted to excise a malformation from a cerebellar hematoma. Imaging studies made during the immediate post-surgery period showed that hemostasis and vacuation of the hematoma had been obtained by an incorrect left-sided procedure. An angiogram indicated bias to the right. Respondent did not perform, or did not document the performance of, a full, pre-surgery neurological evaluation.

B. On or about February 23, 2000, following a CAT scan and angiogram showing an AV (i.e., arteriovenous/atrioventricular) malformation being fed by the superior cerebellar artery and the anterior inferior cerebellar artery, respondent performed surgery on N.J. to excise the malformation and an aneurysm of a feeding artery. This entailed a widening of the opening in the suboccipital area, followed by removal of the feeding vessels and the rest of the arterial venous malformation.

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2. All references to individuals other than Respondent are by initials only to protect the individuals' privacy. The true names of these individuals are known to Respondent and have been or will be revealed to him during pursuant to the discovery procedures codified in Government Code section 11507.6.

Respondent did not document that the lesion was biased to the right. Respondent has stated that N.J.'s head was down on the left side, making it impossible for an entry from the left, but these facts were not documented in respondent's records on N.J. Respondent's operative note indicated that an angiogram was not performed when, in fact, one was done.

C. On or about August 8, 2000, N.J. returned to respondent for post-surgery follow-up. Respondent did not document the performance of more than one surgery in his records for N.J.

D. The following acts and omissions constitute extreme departures from the standard of care:

(1) Respondent failed to plan the craniotomy site correctly.

(2) Respondent failed to use the appropriate approach for the removal of a cerebellar arteriovenous malformation.

(3) By failing to perform a post-surgery angiogram to evaluate the completeness of the removal of the AV malformation; and/or failing to document same.

Patient R.D.

E. On or about April 2 or 3, 1999, Patient R.D., a male, presented to Respondent with complaints of tingling and burning sensations in his thighs and groin area. Respondent had been referred by Patient R.D.'s primary care physician, Dr. Y.

F. Respondent reviewed magnetic resonance imaging forms which previously had been taken of Patient R.D. and which Patient R.D. provided to Respondent. Respondent explained to Patient R.D. that he had "bulging disks" and that surgery was the only available option. Patient R.D. agreed to the surgery which was scheduled for April 9, 1999. Respondent told Patient R.D. that he wold be hospitalized for three days post surgery. Respondent also said that Patient R.D. would be "up and around" in about three months and would be able to resume all normal activities within six months.

G. On the date of surgery, Patient R.D. signed a consent for surgery form. However, no one, including Respondent, explained the risks and complications associated with the surgery to be performed by Respondent. On April 9, 1999, Respondent performed the surgery. Patient R.D. remained hospitalized for 28 days, not three days as advised by Respondent.

H. During his hospitalization, Patient R.D. saw Respondent postoperatively only once. Postoperatively, Patient R.D. had a leakage problem at the surgical site. His primary care physician ordered another MRI; and, after reviewing the MRI, referred Patient R.D. to Dr. M, another physician and surgeon. The MRI revealed that Respondent had performed the surgery on the wrong side and at the wrong level. On August 9, 1999, Dr. M. performed corrective surgery on Patient R.D.

I. The following acts and omissions constitute an extreme departure from the standard of care:

(1) Performing surgery at the wrong location.

(2) Failing to document the patients neurological evaluation and medical management prior to surgery.

(3) Failing to monitor the patient adequately following surgery.

(4) Failing to advise the patient of the risks and complications.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

5. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that Respondent committed repeated negligent acts during his care, treatment and management of Patients N.J., R.D., J.H., O.A., K.A., C.J., M.R., R.M. C.T., and D.M., among others, as follows:

Patient N.J.

A. Respondent refers to and, by the this reference, incorporates Paragraph 4, subparagraphs A through D, inclusive, above, as though fully set forth.

Patient R.D.

B. Respondent refers to and, by the this reference, incorporates Paragraph 4, subparagraphs E through I, inclusive, above, as though fully set forth.

Patient J.H.

C. On or about February 12, 1998, Patient J.H., a 52 year-old female, presented to Respondent with a history of low back and left leg pain, radiating to the left buttock. Respondent did not document the performance of a neurological evaluation, but diagnosed lumbar radiculopathy with lateral stenosis and extensive nerve root adhesions. Respondent performed a decompression and a lysis of the nerve root adhesions. Respondent did not document an indication for this surgery. But a pre-surgery MRI was performed which showed prior surgical changes at L4-5 on the left, consistent with arachnoiditis.

D. On or about February 13, 1998, Patient J.H. experienced difficulty walking. She was left with a numb coccyx and loss of bladder and bowel function.

E. The following acts and omissions constitute departures from the standard of care:

(1) Failing to document the operative report correctly in that the postoperative imaging reports did not support performance of an L3-L4 exploration.

(2) Failing to document neurological evaluations and indications for surgery.

Patient O.A.

F. On or about April 10, 2000, Patient O.A., a 34 year-old male, with a history of impotency and decreased libido, was found to have a large pituitary macro adenoma. Respondent performed a left frontotemporal craniotomy for resection of the tumor. Patient O.A. never regained full consciousness following the surgery, and developed intra cranial pressure as well as elevated blood sugar. A CAT scan revealed

severe edema with a shifting of intra cranial contents.

G. On or about April 12, 2000, Patient O.A. remained hospitalized. Respondent treated O.A. with Mannitol and ventricular drainage, but Patient O.A.'s brain function ceased and he expired.

H. The following acts and omissions constituted departures from the standard of care:

(1) Respondent failed to document a preoperative neurological evaluation (i.e., no consultations reported, no mention of endocrinological work-up in reference to bromocriptine, no report of visual fields).

(2) Respondent failed to document the patient's hormonal studies prior to the craniotomy.

Patient K.A.

I. On or about August 5, 1998, Patient K.A., a 35 year-old female, presented to respondent with complaints of hip and back problems. Respondent documented "continued pain and neurodeficits relative to cervical stenosis."

J. On or about November 18, 1999, Patient K.A. returned to respondent, who noted pain in the upper extremities with decreased strength. A full neurological examination was not performed and/or documented. A presurgery evaluation, including imaging results, was not performed and/or documented. There was no initial intake note, and no documented intake physical and history.

K. On or about February 1, 2000, respondent performed surgery on Patient K.A., which consisted of an anterior cervical discectomy and fusion at C4-5 and C5-6 with instrumentation. During the immediate post-surgery period, Patient K.A. experienced weakness in the upper left extremity and altered consciousness. A CAT scan showed a right cerebellar infarction, with mild hydrocephalus and distortion of the fourth ventricle. In cases of anterior cervical discectomy, vertebral artery injury, though rare, is possible, especially when the side is ipsilateral to the discectomy incision.

L. The following acts and omissions constitute departures from the standard of care:

(1) Respondent failed to perform an adequate pre-surgery neurological evaluation, including imaging studies; and/or failing to document same.

(2) Respondent failed to request a vascular study to diagnose the cause of the cerebellar infarction following the anterior cervical disectomy and fusion.

Patient C.G.

M. On or about February 1, 2000, Patient C.G., a 76 year-old female, presented to Respondent with a history of breast mass, coronary artery disease, and prior L4-5 and L5-6 laminectomies. Patient C.G. complained of low back pain radiating into her left leg and right hip. She required a walker. An MRI of the lower back showed severe scoliosis with spondylosis at L3-4, where there was severe central and foraminal stenosis bilaterally. Respondent suspected a discitis and some abnormal marrow signal at L3-4.

N. On or about February 25, 2000, Patient C.G. presented to Respondent for surgery. The surgery involved an L3 microcorpectomy from the anterior approach, retroperitoneally, and L2-3 and L3-4 microdiscectomy with cage fusion. Respondent did not document the specific indications for this procedure. The choice of an anterior approach for spinal stenosis was improper. There was poor placement of the cages, which use was questionable.

O. On or about March 18, 2000, a CT myelogram performed post-surgery showed the persistence of a complete block at L3-4, with no change in the degree of stenosis from the pre-surgery films. The corpectomy device appeared to have eroded through the posterior cortex.

P. On or about March 22, 2000, Respondent surgically removed the hardware (i.e., titanium cages, plate and screws) from Patient C.G. and made a fusion

with acrylic to fill the space anteriorly. This procedure left Patient C.G. an incomplete paraplegic from the waist down.

Q. Subsequently, Patient C.G. was examined by James Kayvanfor, M.D., an orthopedist, who performed a third surgery on her back, which resulted in a return of her ability to walk.

R. The following act and omission constitutes a departure from the standard of care:

(1) Failing to perform, or document the performance of, a pre-surgery, neurological evaluation.

Patient M.R.

S. On or about November 12, 1999, Patient M.R., a 74 year-old male, presented to Respondent for surgery. Patient M.R. had a history of multiple low back surgeries and persistent discomfort in the lower back and legs. Respondent performed an epiduroscopy with Wydase and epidural steroids. Fifteen minutes into the surgery, Patient M.R. developed intense spasms in both legs, with cramping, requiring endotracheal anesthesia. The cramping was so severe that fractures resulted at the thoracic levels of T9, T10 and T12. A hypertensive crisis ensued. Subsequently, Patient M.R. suffered with a paraparesis (i.e., lower extremity weakness), requiring significant rehabilitation. Respondent did not document a pre-surgery neurological evaluation; nor an indication for the surgery; nor a clear cut reason for the epiduroscopy. No photos were taken during the imagery of the epiduroscopy.

T. The following act and omission constitutes a departure from the standard of care:

(1) Failing to document a pre-surgery neurological evaluation.

Patient R.M.

U. On or about December 12, Patient R.M. a 37 year-old female, presented to Respondent, who diagnosed cervical and thoracic stenosis, with

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radiculopathy and myelopathy. Respondent ordered cervical and thoracic myelogram CT scans.

V. On or about January 2, 2000, Respondent reviewed the results of the CT scans and recommended anterior cervical disectomy and fusion at C5-6 and C6-7.

W. On or about February 4, 2000, Respondent performed the surgery on Patient R.M. Respondent examined Patient R.M. at his office post-surgery, and noted that she was neurologically "stable."

X. On or about March 3, 2000, Patient R.M. returned to her employment.

Y. The following act and omission constitutes a departure from the standard of care:

(1) Failing to perform or, in the alternative, document the performance of, pre-surgery neurological evaluations.

Patient C.T.

Z. On or about May 22, 1997, Patient C.T., a 43 year-old male, was hospitalized for pain control through morphine PCA. Patient C.T. was insulin dependent and had a history of multiple low back surgeries dating to 1996.

AA. On or about June 24, 1997, Patient C.T. was hospitalized by Respondent for the insertion of a lumbar subarachnoid drain to treat pseudomeningocele. Respondent noted "puffiness around the incision," but did not document the performance of a neurological examination.

BB. On or about June 25, 1999, Patient C.T. was hospitalized by Respondent for the placement of a spinal cord stimulator, which was discarded and replaced by a morphine pump. The performance of a neurological evaluation, including consideration of an intrathecal morphine trial, was not documented by Respondent.

CC. On or about March 13, 2000, Respondent performed a T9-10 laminectomy and intradural exploration for a presumed epidural mass, which is not identified in Respondent's records on C.T.

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DD. The following act and omission constitutes a departure from the standard of care:

(1) Failing to document outpatient neurological evaluations and indications for surgery.

Patient D.M.

EE. On or about December 10, 1998, Patient D.M. stated that she felt "an electric shock" down her back. She also complained of arm pain, muffled hearing and memory problems.

FF. In Patient D.M.'s medical chart, Respondent recorded that he observed what he described as decreased extension of the finger on the right and a "trace" decreased strength of the deltoid, minimal paraspinous tenderness, and normal range of motion. Respondent believed that Patient D.M. suffered from radiculopathy for which he prescribe Flexeril and recommended magnetic resonance imaging (MRI).

GG. Patient D.M. executed a written authorization for the release to Respondent of her medical records from previous treating physicians; however, Respondent did not attempt to obtain any of these records.

HH. On or about January 13, 1999, Patient D.M. next presented to Respondent. At that time, she complained of neck and arm pain and persistent weak and numb hands. Respondent did not perform a neurological evaluation or record the progress of the Flexeril. Respondent did not refer Patient D.M. for a psychological consultation. He did not refer the patient for physical therapy. Rather, Respondent strongly suggested that Patient D.M. undergo diskectomy with fusion. Patient D.M. advised that she wanted to seek a second medical opinion before agreeing to the surgery.

II. Before Patient D.M. could obtain a second opinion, Respondent's secretary telephoned Patient D.M. advising her that Respondent had scheduled her for surgery. Because Respondent had informed her that she risked paralysis if she did not have the surgery, she agreed to the procedure which was performed on January 26, 1999.

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JJ. Respondent performed an anterior cervical diskectomy with fusion and plating C5-6 and C6-7. The operative report prepared by Respondent shows that the surgery took two and one half hours; however, Respondent's operative report contains no indication for surgery.

KK. Respondent saw Patient D.M. postoperatively on February 10, March 23, March 31, and August 4, 1999.

LL. The following act and omission constitutes a departure from the standard of care:

(1) Failing to perform a complete neurological examination or, in the alternative, failing to document that he did so.

THIRD CAUSE FOR DISCIPLINE

(Failure To Maintain Adequate and Accurate Records)

6. Respondent is subject to disciplinary action under Business and Professions Code section 2266 in that Respondent failed to maintain adequate and accurate records relating to the provision of services to Patients N.J., R.D., J.H., O.A., K.A., C.J., M.R., R.M. C.T., and D.M., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 4 and 5, above as though fully set forth.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's & Surgeon's Certificate Number A39450, issued to Lorne Houten, M.D.;

2. Revoking, suspending or denying approval of Lorne Houten, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Lorne Houten, M.D., to pay the costs of probation monitoring to the Board if he is placed on probation; and,

4 Taking such other and further action as deemed necessary and proper.

DATED: September 23, 2008

BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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